The leader's work in the improvement of healthcare

Paul Batalden

> "I call it cruel and maybe the root of all cruelty to know what occurs but not recognise the fact"[1]

These are uncertain times, we seem to be on unfamiliar journeys, and there is a deep sense of the need and hope for leadership of the changes we face and that are struggling to be named. Each problem seems to 'cry out in a private language.'[2] How in this context are leaders to make sense of the situation they face?

Each leader has two realities to serve: the current situation and the future that they are trying to create. Leaders communicate what they 'know' to be occurring and what they 'recognise' as fact in the actions they take and in the invitations to act that they offer to others. What might help inform leadership actions and invitations at a time like this?

FOCUS ON BASICS

At the heart of better healthcare that is capable of generating ongoing, sustainable improvement are three inextricably linked aims: a. reducing the burden of illness for individuals and for them as a population; b. improving system quality, safety and value performance; and c. developing and maintaining a lifetime of professional competence, pride and joy in the daily work that includes making these gains.[3]

Focussing on basics with these linked aims means that assessment of outcomes must include an understanding of what system changes and professional competence contributed to them. It means that the development of professional competence includes an understanding of the relation of that competence to the achievement of desired outcomes in the patient and population as well as the intended gains in system quality, safety and value performance.

We have resisted linking these basic aims because we have pretended that competence, joy and pride in health professional work can be separated from achieving system change and better outcomes for individuals and their communities. When they are not linked, we deprive settings and leaders of the energies necessary for generating and sustaining the changes needed. Yet, linking them is not easy when clear responses to urgent mandates for 'less cost' tempt quick, but incomplete responses.

RELENTLESSLY REDUCE WASTE AND ADD VALUE

We have yet to develop a sense of embarrassment about waste in healthcare. Some waste in healthcare is easy to see: needlessly repeated services, procedures and tests; delays experienced, but not required; and added transport because things that needed to be close together were not historically recognised as such.[4] Some waste is harder to see: the information gaps and the behaviours that arise from habit rather than science. Still harder to see are those embedded in the business models we have grown to love, which have the effect of constraining our thinking and design.

Exploring the configuration of best-fitting value models, we can help discover waste in our own work. Using alternative, better-fitting value models we can design approaches to the detection and elimination of waste in clinical care.[5]

Waste also lives in some of our cherished myths, such as the persistent notion that healthcare today is largely a matter of soloist work, independent of the other people and professionals, information and technology that must work well together as functioning systems to achieve the reduction of illness burden in the lives of those served.[6] Every patient knows that the reality is an interdependent one.

Recall the accompanying shame and embarrassment associated with the Japanese word for 'action without value,' *muda*.[4]

SEEK AND USE GOOD SCIENCE

Diverse methods are required for doing 'good science' in healthcare.

The words 'evidence' and 'science' are not interchangeable. For example, what works best for assessing the effectiveness of a drug or new therapy is a randomised controlled trial and what works best to help explain or discover a new approach may be a carefully detailed case report.[7] We can be clear about which methods work best for what situation and model the integration of science into our own daily work.

We have no choice but to honour the diverse ways of knowing that underpin the obligatory interactions of 'evidence-based medicine' and 'quality improvement.' Our old habits of 'doing biomedical science' and 'achieving social change' must be seen as a synergistic invitation to leaders to bring very different traditions together and to foster learning from the experience of designing and making real and needed change.

ENABLE CONTINUAL INQUIRY INTO THE 'UNCHANGED PRESENT' AND OFFER THE SOCIAL SUPPORT THAT FOSTERS IT

Living systems continually change in response to the circumstances around them and within them. Change is resisted as a manifestation of the competing commitments and assumptions working together to hold the unchanged present in place.[8 9] Inquiry into the unchanged present involves understanding both the driving and the restraining, competing forces.

Change mastery requires habits that seek understanding of actual daily performance—in context—and its contrast with theoretic limits of what is possible. Fostering the never-ending desire to improve requires social support that appreciates the creativity, the discipline, the courage and the satisfaction that comes with changing one's own work.

As Paul O'Neill observed, work places with the potential for greatness make it possible for everyone to affirm that:

1. "I'm treated with dignity and respect everyday by everyone I encounter-…and it doesn't have anything to do with hierarchy."
2. "I'm given the things I need to make a contribution that gives meaning to my life."
3. "Someone noticed that I did it."[10]

RECOGNISE AND FOSTER COMMUNITY

There is a mode shift underway. New levels of cooperation among people from different disciplines and organisations will be required. The competitive drives might change from a focus on 'Us versus Them' to become a collaborative competition against the unmet social need for health, continually informed by the development

Correspondence to Professor Paul Batalden, Professor of Pediatrics, Community and Family Medicine and The Dartmouth Institute for Health Policy and Clinical Practice, Dartmouth Medical School, Lebanon, New Hampshire 03766, USA; paul.batalden@gmail.com

of the science of the delivery of value. This can build camaraderie and appreciation for diverse gifts, ideas and talents.

If our aim is large enough, we know we can't make it alone and that cooperation with others is obligatory, not merely a preference. We need to overcome the deep habits which have fostered unnecessary competition among people and the implicit covenants of neglect about unmet need.

The need and the tasks are much larger than one life-career-space. Enjoy and encourage each other—and others in the community of practice. The design lessons from the alignment of providers and the beneficiaries of care in the early HIV-AIDS experience offer a striking example of what can happen.[11]

Recognise that if we are going to be able to work better together, we have to be prepared to make promises to one another and to be prepared to seek forgiveness for those promises not kept.[12]

The words popularly attributed to Albert Einstein are a helpful reminder: "*We cannot hope to solve problems with the same level of thinking that created them.*"

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